Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution-General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on July 19, 2004.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of the issues of medical necessity. All office visits (except 11-11-03, 11-24-03, 12-09-03, 12-15-03 and 12-23-03), E0230-ice cap, 97750-physical performance test, all 97140-manual therapy technique, 97110-therapeutic exercises (maximum of 2 units per date of service) and 97018-paraffin bath and ultrasound from 10-30-03 through 11-17-03 **were found** medically necessary. The office visits on 11-11-03, 11-24-03, 12-09-03, 12-15-03 and 12-23-03, 99082-unusual travel, A4556-batteries, E1399-DME misc, A6430-bandage, E0235-paraffin bath unit, 97124-massage, A4265-paraffin and 97110-therapeutic exercises in excess of the approved **were not found** medically necessary. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 01-14-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
11-21-03 01-08-04 02-09-04 03-05-04	99080-73	$20.00 x 4	$0.00	V	$15.00 x 4 = $60.00	Rule 133.106(f)(1)	The TWCC-73 is a required report and is not subject to an IRO review. Therefore, will be reviewed in accordance with rule 133.106(f)(1). Recommend reimbursement of $60.00.
TOTAL		$80.00					The requestor is entitled to reimbursement of $60.00.

This Findings and Decision is hereby issued this 28th day of January 2005.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) and in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 10-30-03 through 03-05-04 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 28th day of January 2005.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/pr

Enclosure: IRO Decision

September 13, 2004

TEXAS WORKERS COMP. COMISSION
AUSTIN, TX 78744-1609

CLAIMANT:
EMPLOYEE:
POLICY: M5-04-4128-1
CLIENT TRACKING NUMBER: M5-04-4128-1/ 52

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIoA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIoA for independent review.

Records Received:

1. Notification of IRO assignment dated 4/27/04
2. Letter from Texas Worker's Compensation Commission dated 8/27/04
3. Medical dispute resolution request/response form for dates 10/30/03 through 3/5/04
4. EOB forms for dates 10/30/03 through 3/15/04
5. Office visit reports for 8/6/02 through 8/30/04
6. Operative reports dated 9/25/02, 10/8/03, 4/7/04
7. Discharge summary dated 9/25/02, 10/8/03, 4/7/03
8. Request for reconsideration for dates of service 10/30/03 through 3/14/04
9. Letter from Dr. Hood dated 10/14/03
10. Re-examinations dated 10/30/03 and 12/9/03
11. Letters from Dr. Dillin dated 10/17/03, 10/24/03, 12/8/03, 4/1/04
12. Physical therapy prescriptions dated 10/24/03, 12/8/03
13. Daily notes dated 7/1/02 through 3/5/04
14. Electrophysiology report dated 6/3/02
15. High resolution triphasic bone scan or the hands and writs dated 2/24/03
16. MRI of the right hand dated 7/17/02
17. Physical performance evaluation reports dated 1/2/04, 12/4/03
18. Durable medical equipment certification of medical necessity/deliver tickets dated 3/15/04, 2/16/04, 1/15/04, 12/15/03, 11/17/03, 11/3/03, 3/21/02, 10/30/03,

Summary of Treatment/Case History:

The patient underwent surgery and postoperative rehabilitative treatment after sustaining a work-related injury to her right hand, wrist and elbow on ___.

Questions for Review:

1. Were the office visits, #E0230-Ice Cap; #97035-ultrasound; #97018-Paraffin Bath; #97140-Manual therapy technique; #99082-Unusual travel; #A4556-Batteries; #E1399-DME misc; #A6430-Bandage; #E0235-Paraffin Bath Unit; #97750-Physical Performance Test; #97110-Therapeutic

Exercises; #A4566-Splint; #97124-Massage; and #A4265-Paraffin from 10/30/03 to 3/5/04 medically necessary to treat this patient's injury?

Conclusion/Partial Decision to Certify:

1. Were the office visits, #E0230-Ice Cap; #97035-ultrasound; #97018-Paraffin Bath; #97140-Manual therapy technique; #99082-Unusual travel; #A4556-Batteries; #E1399-DME misc; #A6430-Bandage; #E0235-Paraffin Bath Unit; #97750-Physical Performance Test; #97110-Therapeutic Exercises; #A4566-Splint; #97124-Massage; and #A4265-Paraffin from 10/30/03 to 3/5/04 medically necessary to treat this patient's injury?

From 10/30/03 to 1/2/04, all office visits (except 11/11/03, 11/24/03, 12/9/03, 12/15/03 and 12/23/03) are approved as medically necessary; #E0230-ice cap is approved as medically necessary; #97750-physical performance test is approved as medically necessary; all #97140-manual therapy technique is approved as medically necessary; and #97110-therapeutic exercises (maximum of two units per date of service) are approved as medically necessary. From 10/30/03 to 11/17/03, #97035-ultrasound and #97018- paraffin bath are approved as medically necessary.

All other treatment, supplies, examinations and office visits are denied as not medically necessary.

Rationale: Physical medicine is an accepted part of a rehabilitation program following injury and/or surgery. However, for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time period (reference 1). In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. General expectations include: (A) Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue. (B) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (C) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment. Some of the passive and active treatment in this case, as indicated previously, met those criteria.

Moreover, some of the treatment from 10/30/03 to 1/2/04 met the statutory requirements (reference 2) since the patient obtained relief, promotion of recovery was accomplished and there was an enhancement of the employee's ability to return to employment. Specifically, the patient's wrist range of motion and strength testing dramatically increased according to the PPEs performed on 12/4/03 and 1/2/04.

However, much of the treatment was not indicated, medically necessary or supported.

It is the position of the Texas Chiropractic Association (reference 3) that it is beneficial to proceed to the rehabilitation phase (if warranted) as rapidly as possible, and to minimize dependency upon passive forms of treatment/care since studies have shown a clear relationship between prolonged restricted activity and the risk of failure in returning to pre-injury status. The TCA Guidelines also state that repeated use of

acute care measures alone generally fosters chronicity, physician dependence and over-utilization and the repeated use of passive treatment/care tends to promote physician dependence and chronicity. Therefore, all ultrasound treatments (#97035); paraffin bath treatments (#97018); EMS electrodes (#A4556) and batteries (#A4630); and massage (#97124) after 11/17/03 are denied. The paraffin bath unit (#E0235) on 11/17/03 is denied for the same reason.

No medical records were supplied to document that the treating doctor saw the patient on 11/11/03, 11/24/03, 12/9/03, 12/15/03 or 12/23/03. Therefore, the focused office visits (#99212) are denied for those dates of service. No medical records were supplied to document the medical necessity of the office visits (#99212) on 1/8/04 and 3/5/04. No records were supplied to document the medical necessity of unusual travel (#99082), bandage (#A6430), DME (#E1399) and Splint (#A4566). No records were supplied to the document the medical necessity of therapeutic exercises (#97110) in excess of two units on 12/22/03, 12/23/03, 12/24/03, 12/29/03, 12/30/03 and 12/31/03.

References Used in Support of Decision:

1. Haldeman, S; Chapman-Smith, D; Petersen, D Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen Publishers, Inc.
2. Texas Labor Code 408.021
3. Quality Assurance Guidelines, Texas Chiropractic Association.

This review was provided by a Chiropractor who is certified by the National Board of Chiropractic Examiners. This reviewer is a member of the American Chiropractic Association, the National Chiropractic Legal Action Fund and the Federation of State Medical Boards. This reviewer has written numerous publications and given several presentations within their field of specialty. This reviewer has been in active practice since 1977.

MRIoA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the revibewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIoA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIoA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIoA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIoA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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